

<input type="radio"/> MR <input type="radio"/> MRS <input type="radio"/> MS <input type="radio"/> MISS <input type="radio"/> DR	SURNAME	FIRST NAME
ADDRESS		DOB / /
EMAIL		NHI #
PHONE (HOME)	PHONE (MOBILE)	ACC #
		INSURER #

3T MRI	3T MRI	XRAY	CT	ULTRASOUND
<input type="radio"/> C SPINE <input type="radio"/> T SPINE <input type="radio"/> L SPINE <input type="radio"/> Shoulder <input type="radio"/> Elbow <input type="radio"/> Wrist <input type="radio"/> Finger/Thumb <input type="radio"/> Pelvis <input type="radio"/> Hip <input type="radio"/> Knee <input type="radio"/> Ankle <input type="radio"/> Foot <input type="radio"/> Arthrogram	<input type="radio"/> Brain <input type="radio"/> Angiogram <input type="radio"/> Chest <input type="radio"/> Abdomen <input type="radio"/> Other _____ INTERVENTION <input type="radio"/> Steroid Injection <input type="radio"/> PRP Injection <input type="radio"/> Nerve Root Injection <input type="radio"/> Facet Joint Injection <input type="radio"/> Other _____	<input type="radio"/> General <input type="radio"/> Other _____ NUCLEAR MEDICINE <input type="radio"/> Bone SPECT-CT <input type="radio"/> Whole Body Bone scan <input type="radio"/> Other _____ EOS <input type="radio"/> Spine <input type="radio"/> Lower limb	<input type="radio"/> Musculoskeletal Spine <input type="radio"/> Musculoskeletal Other _____ <input type="radio"/> Head <input type="radio"/> Angiogram <input type="radio"/> Sinus <input type="radio"/> Neck <input type="radio"/> Chest <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> Other _____	<input type="radio"/> Musculoskeletal ± X-Ray <input type="radio"/> Injection <input type="radio"/> Aspiration <input type="radio"/> Upper abdomen <input type="radio"/> Renal <input type="radio"/> Pelvis <input type="radio"/> Obstetrics <input type="radio"/> Carotid <input type="radio"/> DVT <input type="radio"/> Other _____

REGION OF INTEREST / PROCEDURE	ALERTS	URGENCY
	<input type="radio"/> Renal Impairment eGFR _____ <input type="radio"/> Contrast Allergy <input type="radio"/> Anticoagulants <input type="radio"/> Pacemaker <input type="radio"/> Neuro/Biostimulator <input type="radio"/> Other _____	<input type="radio"/> URGENT <input type="radio"/> Routine <input type="radio"/> Other _____
CLINICAL DETAILS	Is the Patient a Diabetic? <input type="radio"/> Yes <input type="radio"/> No Is the Patient Pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure <input type="radio"/> N/A	

REFERRING PRACTITIONER

NAME	POSITION
CONTACT DETAILS	NZMC #

SIGNED	DATE / /	PATIENT FOLLOW UP APPOINTMENT:	DATE / /
--------	----------	--------------------------------	----------

I WOULD LIKE THE REPORT SENT TO ME BY EDI FAX EMAIL (PLEASE INCLUDE DETAILS ABOVE)

As a consumer, you have the right to choose another provider for your imaging.



REFERRAL FORM

HOW TO FIND US



Beyond Radiology

**110 Grafton Road
Auckland 1010**

BY VEHICLE there is patient parking at 110 Grafton Road. From there, take the lift or stairwell to reception.

ON FOOT you will find our pedestrian entrance on Park Road.



ALL PATIENTS: Please bring any previous relevant medical imaging with you to your appointment.